



MAIWHC

Montana American Indian Women's Health Coalition Membership Form

☐ I AM INTERESTED IN SERVING ON MAIWHC:

Last Name:_____ First Name:_____ Middle Initial:_____

Credentials:_____ Salutations:_____ Site:_____

Job Title:_____ Organization:_____

Shipping address:_____ City:_____ State:_____ Zip:_____

Email:_____ Phone:_____ Alt Phone:_____ Fax:_____

Signature:_____ Date:_____

☐ I AM NO LONGER INTERESTED IN SERVING ON MAIWHC:

Reason for resigning:_____

Signature:_____ Date:_____

☐ I RECOMMEND THE FOLLOWING BE INVITED TO SERVE ON MAIWHC:

Last Name:_____ First Name:_____ Middle Initial:_____

Mailing address:_____ City:_____ State:_____ Zip:_____

Email:_____ Phone:_____ Alt Phone:_____ Fax:_____

Signature:_____ Date:_____